LOUISIANA PATIENT'S COMPENSATION FUND
DENTIST APPLICATION
(FOR THOSE WITH PRIMARY INSURANCE)

1: PROVIDER DETAILS

****Complete Name & Mailing Address :

_____

_____

_____

_____

LICENSE #:_____

Date of Birth: _____

Professional Specialty:

_____

PCF Code: _____

PH. #_____ EMAIL:_____

2: PRIMARY COVERAGE – The COI or declarations page from the insurer's policy is REQUIRED.

Insuring Company: _____

Policy #:_____ Effective Dates: _____ to _____

Retro Date (if applicable)***: _____Policy Form: __ Claims Made*** **OR** __ Occurrence

Primary Premium:_____ PCF Surcharge:_____

Professional Liability Limits:_____ Each Claim/_____ Aggregate

Do you work part time? _____ Number of hrs/week? _____ **Complete form PCF 12**

****IF COVERAGE IS IN PLACE FOR A CORPORATION, PLEASE PROVIDE A SEPARATE CERTIFICATE OF INSURANCE, AS WELL AS COMPLETING THE CORPORATION APPLICATION (PCF9), WHICH CAN BE FOUND ON OUR WEBSITE www.doa.louisiana.gov/pcf.**

Must advise the PCF of any offsite entities or multiple practice locations for which coverage is provided along with the address for each location and proof of underlying coverage.

EMPLOYEES AS ADDITIONAL INSUREDS: Please complete the additional insured addendum (PCF15) and include proof of underlying coverage.

NOTE:
Failure to comply with cost and reserve reporting requirements set forth in LAC 37:III, §§1101-1105 could result in termination of PCF coverage.

INCLUSIONS:
Employed allied healthcare providers. This does not include those who require a PCF surcharge, such as, NP's, PA's, CNS', CRNA's, etc.

PCF RESERVES THE RIGHT TO DENY COVERAGE FOR THE FOLLOWING:

(1) Injury arising out of a criminal act, including but not limited to sexual abuse or molestation, fraud committed by the insured or any person for whom the insured is legally responsible, and battery.
(2) Third (3rd) party claims filed by an injured party that was not a patient of the health care provider.
(3) Services or treatment rendered as a licensed provider in states other than Louisiana, even if the underlying insurer provides coverage for same.

Please indicate answers to questions below. Fully explain any "yes" answer in space allowed.

		YES	NO
a.	Do you practice dentistry outside of Louisiana?		
b.	Do you provide care at a Correctional Institute?		
c.	Has membership in any professional association or society ever been revoked?		
d.	Has any hospital suspended, restricted or refused you staff privileges?		
e.	Have you ever voluntarily surrendered or had a state license to practice dentistry refused, suspended or revoked?		
f.	Have you ever voluntarily surrendered or had a narcotics license refused, suspended or revoked?		
g.	Have you ever been treated for alcoholism, narcotic addiction or mental illness?		
h.	Have you ever been convicted of a crime?		
i.	Have you ever had any chronic illness or physical defect?		
j.	Have you ever had any professional liability insurance refused, cancelled or non-renewed?		
k.	Do you work in any emergency room or industrial medical facility?		
l.	Do you own, operate or supervise the operation of any hospital or sanitarium?		
m.	Have any claims or suits been filed against you during the past 5 years as a result of professional services rendered?		

Details on "yes" answers (please identify by letter): _____

_____

_____

_____

_____

Please indicate which of the following medical procedures you engage in:

	Administer general anesthesia
	Administer local anesthesia
	Botox Injections or facial fillers
	Orthodontics
	Other

***CLAIMS-MADE POLICY:

Your primary insurance policy provides CLAIMS MADE coverage for professional liability. Except to the extent as may otherwise be specifically provided in your policy, such primary coverage is limited to claims arising from medical incidents occurring on or after the initial effective date stated in the declarations ("retroactive date") and first reported to your company while the policy is in force. HOWEVER, THE PCF RETROACTIVE DATE IS THE DATE OF YOUR QUALIFICATION WITH THE FUND, WHICH MAY OR MAY NOT MATCH THE RETROACTIVE DATE ESTABLISHED ON YOUR PRIMARY POLICY. Claims occurring prior to the qualification date with the Fund, REGARDLESS OF THEIR COVERAGE THROUGH YOUR PRIMARY POLICY, are not covered by the Fund.

It is further acknowledged that in the event of termination of policy herein, or any endorsed reduction of liability limits, such termination or change shall not be effective unless such notice of the same has been delivered to the Louisiana Patients' Compensation Fund not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Mail, a copy of which shall have been mailed to the Health Care Provider.

3: LOUISIANA PATIENTS' COMPENSATION FUND

It is agreed that the insured under the above primary limits has been advised by the Company's Agent:

(1) that he or she is eligible to qualify for coverage under the Louisiana Patients' Compensation Fund for the provisions of La. R.S. 10:1299.41 et seq., as a "health care provider" that is already carrying underlying malpractice liability coverage at limits of $100,000/$300,000 or more:

(2) that to qualify, the insured undertakes to pay the required surcharge, and this surcharge will be collected by the Company's Agent and remitted to the Fund on a calendar-year basis; and

(3) that if qualified, the insured is entitled to a $500,000 limitation of malpractice liability for death, or injury to any person and to coverage under that Fund for an excess liability (over the minimum underlying limits required by the Fund) up to a per claim limit of $500,000.

(4) **CLAIMS MADE PRIMARY POLICIES ONLY:**

I understand that, regardless of the retroactive date established by my primary policy, I will only receive coverage through the Fund for claims which occur after my qualification with the Fund. For a claim to be covered by the Patients' Compensation Fund, I must have been qualified with the Fund both at the time the medical incident occurred, and at the time the claim was filed with my primary carrier.

TO: LOUISIANA PATIENT'S COMPENSATION FUND
P. O. BOX 3718
BATON ROUGE, LA 70821
FAX: (225) 362-5265

_____ _____

DATE

Signature of Insured
NOT VALID WITHOUT SIGNATURE

PCF coverage is subject to all agreements, conditions and exclusions of the underlying policy unless such agreements, conditions and exclusions are expressly prohibited by law.